PRINTED: 07/12/2011

| DEPARTMEN' | Γ OF HEALTH AND HU! | MAN SERVICES | | | FO | RM APPROVED |
|------------|---|--------------------------------|------------------|---|-----------|------------------|
| CENTERS FO | R MEDICARE & MEDIC | CAID SERVICES | | | OM | IB NO. 0938-0391 |
| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE | SURVEY |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 01 | COMPI | |
| | | 155730 | B. WING | | 06/15/2 | 2011 |
| NAME OF | PROVIDER OR SUPPLIE | R. | STREET | ADDRESS, CITY, STATE, ZIP CODE | • | |
| TVILVIL OF | THO VIDER OR SOLVED | | 1200 W | VHITLATCH WAY | | |
| RIPLEY | CROSSING | | MILAN, | , IN47031 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` ` | NCY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | | DATE |
| K0000 | | | | | | |
| | A Life Sefety Co | ada Dagartification and | K0000 | K00 The filing of this plan of correction does not constitute an | | |
| | 1 | ode Recertification and | KUUUU | | | |
| | State Licensure Survey was conducted by the Indiana State Department of Health in | | | admission that the alleged | | |
| | | • | | deficiency did in fact exist. | This | |
| | accordance with | 42 CFR 483.70(a). | | plan of correction if filed as | | |
| | | | | evidence of the facilities decomply with the regulation v | | |
| | Survey Date: 06 | 5/15/11 | | continuing to provide quality | | |
| | | | | care to all residents. | | |
| | Facility Number | | | | | |
| | Provider Number | er: 155730 | | | | |
| | AIM Number: | 100266230 | | | | |
| | | | | | | |
| | Surveyor: Mark | Bugni, Life Safety Code | | | | |
| | Specialist | | | | | |
| | | | | | | |
| | At this Life Safe | ety Code survey, Ripley | | | | |
| | Crossing was fo | und not in compliance | | | | |
| | with Requireme | nts for Participation in | | | | |
| | | eaid, 42 CFR Subpart | | | | |
| | | Safety from Fire and the | | | | |
| | ` ' ' | the National Fire | | | | |
| | | ciation (NFPA) 101, Life | | | | |
| | | SC), Chapter 19, Existing | | | | |
| | | cupancies, NFPA 101, Life | | | | |
| | | SC) and 410 IAC 16.2. | | | | |
| | · ` ` | | | | | |
| | 1 | lding was surveyed with | | | | |
| | Chapter 19, Exis | sting Health Care | 1 | 1 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a two hour separation from Wing 5 labeled as the

> TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Occupancies.

Event ID:

J9VX21

Facility ID:

000420

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY (X3) DATE SURVEY (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X3) DATE SURVEY (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X4) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLI | | ETED | | | | |
|--------------------------|--|--|------|---------------------|---|-------------|----------------------------|
| | PROVIDER OR SUPPLIER | | • | 1200 WI | DDRESS, CITY, STATE, ZIP CODE HITLATCH WAY IN47031 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| K0025 SS=E | the original build separation from V Wing to the south building. The fact system with smood corridors, spaces and all resident separations of 95 at the Quality Review by F Safety Code Special 06/16/11. The facility was four aforementioned regularity evidenced by the following spanels and separate complete the penetrations of smoke sparate complete spanels and separate spanels and separate complete spanels and separate spa | ing to the northwest of ling and a two hour Wing 4 to the Residential heast of the original cility has a fire alarm ke detection in the open to the corridors, leeping rooms. The acity of 100 and had a he time of this visit. Robert Booher, REHS, Life ist-Medical Surveyor on had not in compliance with the alatory requirements as lowing he constructed to provide at our fire resistance rating in an | K0 | 0025 | K025 1.What corrective active will be accomplished: Replacement of the fire caulty and 2 metal flanges were screwed in to close all gaps around the duct. 2. How other residents have the potential be effected: All residents have | ner I to | 06/30/2011 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

J9VX21

Facility ID: 000420

If continuation sheet

Page 2 of 17

| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP | PLE CON | STRUCTION | (X3) DATE S COMPL | |
|---------------|--|--|---|----------|--|----------------------|--------------------|
| ANDIEAN | or connection | 155730 | A. BUILDING | G | 01 | 06/15/2 | |
| | | | B. WING _ STI | REET AD | DDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | IITLATCH WAY | | |
| RIPLEY (| CROSSING | | MI | ILAN, II | N47031 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREF TA | - 1 | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | COMPLETION DATE |
| | | e main dining room, | | | the potential to be effected. | 3. | 2.112 |
| | _ | adjacent to the laundry | | | What measures/changes have | | |
| | room. | | | | been put in place: Maintenance supervisor will monitor the area | | |
| | | | | | every day x 2 weeks, then d | | |
| | Findings include | : | his rounds. 4. How this corrective action will be | | | | |
| | Based on observa | ation with the | | | monitored: Administrator or | | |
| | | ervisor on 06/15/11 at | | | designee will monitor to ens the measures are being | | |
| | 1:50 p.m., the lat | | | | completed. 5. What date the | ese | |
| | collection room | located behind the dryers | | | changes will be completed: | June | |
| | had two duct pen | etrations through the | | | 30, 2011 | | |
| | ceiling with two | inch to four inch gaps | | | | | |
| | | penetrations which was | | | | | |
| | | This was verified by the | | | | | |
| | maintenance supervisor at the time of observation. | | | | | | |
| | | | | | | | |
| | 3.1-19(b) | | | | | | |
| K0052 | _ | m required for life safety is | | | | | |
| SS=F | installed, tested, a | nd maintained in IFPA 70 National Electrical | | | | | |
| | | 2. The system has an | | | | | |
| | approved mainten | ance and testing program | | | | | |
| | | plicable requirements of 9.6.1.4 | | | | | |
| | | ation and interview, the | K0052 | , | K52 1.What corrective action | า will | 06/30/2011 |
| | | provide a fire alarm | 110032 | | be accomplished: The autor | matic | 50,50,2011 |
| | | gnal in a location likely | | | dialer box was replaced. 2 How other residents have the | | |
| | | cility staff in accordance | | | potential to be effected: All | , | |
| | _ | Vational Fire Alarm Code. | | | residents have the potential t | o be | |
| | NFPA 72, 1-5.4.6 | 6 requires trouble signals | | | effected. 3. What measures/changes have been | an | |
| | | in area where it is likely | | | put in place: The automatic | | |
| | | be heard. NFPA 72, 1-5.4.4 requires | | | will be checked 3 times per | | |
| | fire alarms, super | rvisory signals, and | | | week times 1 month then | | |

| | | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY |
|------------|--|------------------------------|--------|------------|--|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 01 | COMPLETED |
| | | 155730 | B. WIN | | | 06/15/2011 |
| NAME OF P | PROVIDER OR SUPPLIER | Ц | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | • |
| NAME OF P | ROVIDER OR SUFFLIER | | | 1 | HITLATCH WAY | |
| RIPLEY (| CROSSING | | | MILAN, | IN47031 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE |
| TAG | | LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | DATE |
| | _ | be distinctive and | | | monthly. 4. How this correct action will be monitored: | tive |
| | 1 2 | unciated. This deficient | | | Administrator or designee w | ill l |
| | • | fect all residents, staff | | | monitor monthly. 5. What of | |
| | and visitors. | | | | these changes will be | |
| | | | | | completed: June 30, 2011 | |
| | Findings include: | · · | | | | |
| | | | | | | |
| | | ervation and fire alarm | | | | |
| | | naintenance supervisor | | | | |
| | | 30 p.m., when the | | | | |
| | automatic dialer | component was placed in | | | | |
| | trouble from phone line failure for twenty | | | | | |
| | five minutes, the local trouble signal was | | | | | |
| | not initiated at th | e digital dialer box | | | | |
| | located in the fro | nt entrance which was | | | | |
| | not continually o | ccupied by facility staff, | | | | |
| | or at the fire alar | m system subpanel | | | | |
| | located at the Wi | ng 4 nurses' station. | | | | |
| | Based on an inter | rview with the | | | | |
| | maintenance supe | ervisor on 06/15/11 at | | | | |
| | 3:50 p.m., the fire | e alarm system had an | | | | |
| | electrical problen | n a few months ago and | | | | |
| | the fire alarm sys | stem contractor | | | | |
| | | trouble signal from the | | | | |
| | | did not reconnect the | | | | |
| | • | Based on observation of | | | | |
| | _ | stem electrical panel with | | | | |
| | - | supervisor on 06/15/11 at | | | | |
| | | ectrical wiring feeding the | | | | |
| | • | is visibly disconnected. | | | | |
| | | , | | | | |
| | 3.1-19(b) | | | | | |
| | ` ′ | | | | | |
| | | | | | | |
| FORM CMS-2 | 567(02-99) Previous Version | ons Obsolete Event ID: | J9VX21 | Facility I | ID: 000420 If continuation s | sheet Page 4 of 17 |

| STATEME | ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|----------|--|------------------------------|----------------------------|--------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 01 | COMPL | ETED |
| | | 155730 | B. WIN | | | 06/15/2 | 011 |
| | | <u> </u> | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF | PROVIDER OR SUPPLIEF | · · | | 1200 W | /HITLATCH WAY | | |
| | CROSSING | | | | IN47031 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | 17.0 | TAG | K52 1.What corrective action | النبد | DATE |
| | | ration and interview, the | K | 0052 | be accomplished: The auto | | 06/30/2011 |
| | facility failed to provide a fire alarm system trouble signal in a location likely to be heard by facility staff in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals | | | | dialer box was replaced. 2 | | |
| | | | | | How other residents have the | | |
| | | | | | potential to be effected: All | | |
| | | | | | residents have the potential | to be | |
| | | | | | effected. 3. What measures/changes have be | en | |
| | to be located in a | an area where it is likely | | | put in place: The automatic | | |
| | to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and | | | | will be checked 3 times per | | |
| | | | | | week times 1 month then | | |
| | trouble signals to | o be distinctive and | | | monthly. 4. How this correct | tive | |
| | descriptively and | nunciated. This deficient | | | action will be monitored: Administrator or designee wi | II | |
| | practice could affect all residents, staff and visitors. | | | | monitor monthly. 5. What da | | |
| | | | | | these changes will be | | |
| | | | | | completed: June 30, 2011 | | |
| | Findings include | | | | | | |
| | | | | | | | |
| | | ervation and fire alarm | | | | | |
| | testing with the | maintenance supervisor | | | | | |
| | on 06/15/11 at 3 | :30 p.m., when the | | | | | |
| | automatic dialer | component was placed in | | | | | |
| | trouble from pho | one line failure for twenty | | | | | |
| | five minutes, the | e local trouble signal was | | | | | |
| | not initiated at th | ne digital dialer box | | | | | |
| | located in the fro | ont entrance which was | | | | | |
| | not continually of | occupied by facility staff, | | | | | |
| | or at the fire alar | m system subpanel | | | | | |
| | located at the W | ing 4 nurses' station. | | | | | |
| | Based on an inte | erview with the | | | | | |
| | maintenance sup | pervisor on 06/15/11 at | | | | | |
| | 1 | re alarm system had an | | | | | |
| | 1 * ' | m a few months ago and | | | | | |
| | the fire alarm sy | <u> </u> | | | | | |
| | 1 | e trouble signal from the | | | | | |
| | 1 | did not reconnect the | | | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155730 NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) electrical wiring. Based on observation of the fire alarm system electrical panel with A. BUILDING D1 COMPLETED 06/15/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN47031 STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN47031 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE COMPLETICATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MU | JLTIPLE CO | NSTRUCTION | (X3) DATE S | SURVEY |
|--|---|--|---|---------|------------|--|---|------------|
| NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) RIPLEY CROSSING (X5) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | AND PLAN OF | F CORRECTION | IDENTIFICATION NUMBER: | Δ RIIII | DING | 01 | COMPL | ETED |
| NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN47031 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) Electrical wiring. Based on observation of | | | 155730 | ı | | | 06/15/2 | 011 |
| PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE electrical wiring. Based on observation of | | | | | 1200 W | HITLATCH WAY | | |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE electrical wiring. Based on observation of | (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| electrical wiring. Based on observation of | PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ΓE | COMPLETION |
| | | | | | TAG | DEFICIENCY) | | DATE |
| the maintenance supervisor on 06/15/11 at 3:55 p.m., the electrical wiring feeding the trouble signal was visibly disconnected. 3.1-19(b) K0144 SS=F Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. | K0144 SS=F | the fire alarm system maintenance 3:55 p.m., the electrouble signal was 3.1-19(b) Generators are insexercised under low month in accordar 3.4.4.1. 1. Based on object of 1 emergency equipped with a LSC 7.9.2.3 recognerators prove emergency light installed, tested accordance with for Emergency Systems. NFP 3-5.5.6 requires shall have a restation of a type break-glass statte room housi NFPA 37, Standard Use of Statengines and Gedition, at 8-2.2 of 100 horsepo | stem electrical panel with supervisor on 06/15/11 at ectrical wiring feeding the as visibly disconnected. spected weekly and bad for 30 minutes per nee with NFPA 99. beservation and acility failed to ensure 1 by generators was a remote manual stop. Quires emergency widing power to enting systems shall be and maintained in the NFPA 110, Standard and Standby Power PA 110, 1999 edition, as Level I installations mote manual stop e similar to a lation located outside and the prime mover. In the located outside and the prime mover. In the located outside and standby Power example as a lation located outside and the prime mover. In the located outside and the prime mover. In the located outside are the located outside as Turbines, 1998. In the located engines are remote more have | К0 | 144 | will be accomplished: The labank test will becompleted at least every year. This general does not require a remote mastopdue to its size, (see attacketer). 2. How other resident havethe potential to be effected: All residents have the potential to be effected. All residents have the potential to be effected. 3. When the will be effected annually duringscheduled semi annually duringscheduled semi annual visits. 4. How this corrective action will be monitored: Administrator or designeewill monitor. 5. | oad t ator anual ched, s ne hat en est | 07/11/2011 |

| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SU COMPLE | |
|-----------|---|--|----------------|------------|--|------------------------|------------|
| AND PLAIN | OF CORRECTION | 155730 | A. BUI | | 01 | 06/15/20 | |
| | | 100700 | B. WIN | | DDDEGG CITY GTATE ZID CODE | 00/10/20 | '' |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE HITLATCH WAY | | |
| RIPLEY (| CROSSING | | MILAN, IN47031 | | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | \neg | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | _ | nd from a remote | | | | | |
| | | deficient practice could | | | | | |
| | affect all reside | nts. | | | | | |
| | Findings includ | e: | | | | | |
| | Based on obse | rvation of the | | | | | |
| | | nerator set and a tour | | | | | |
| | | ith the maintenance | | | | | |
| | supervisor on C | 06/15/11 from 12:10 | | | | | |
| | p.m. to 4:05 p.m., there was no emergency stop switch located | | | | | | |
| | | | | | | | |
| | | ergency generator set | | | | | |
| | building, or in the | - | | | | | |
| | | nerator set was a six and lacked a listing of | | | | | |
| | _ | r on the nameplate on | | | | | |
| | - | engine. Based on an | | | | | |
| | | he maintenance | | | | | |
| | supervisor on 0 | 06/15/11 at 3:45 p.m., | | | | | |
| | the diesel gene | erator is over one | | | | | |
| | hundred horser | oower. | | | | | |
| | 3-1.19(b) | | | | | | |
| | 2. Based on reco | rd review and interview, | | | | | |
| | | to ensure the load | | | | | |
| | _ | st 12 months was | | | | | |
| | | operating conditions or | | | | | |
| | | percent of the nameplate | | | | | |
| | _ | ergency generator set to | | | | | |
| | protect 95 of 95 | residents. Chapter | | | | | |
| | 3-4.4.1.1 of NFP | A 99 requires monthly | | | | | |
| | testing of the ger | nerator serving the | | | | | |
| | | | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CC | | (X3) DATE SURVEY COMPLETED |
|---------------|--|--|------------------|--|-------------------------------|
| AND PLAN | OF CORRECTION | 155730 | A. BUILDING | 01 | 06/15/2011 |
| | | 100700 | B. WING | ADDRESS, CITY, STATE, ZIP CODE | 00/10/2011 |
| NAME OF F | PROVIDER OR SUPPLIER | | | HITLATCH WAY | |
| | CROSSING | | MILAN, | IN47031 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION DATE |
| IAG | | rical system to be in | IAG | , | DAIL |
| | | NFPA 110, the Standard | | | |
| | | nd Standby Powers | | | |
| | | - | | | |
| | Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level | | | | |
| | • | vice to be exercised | | | |
| | | | | | |
| | | conditions or not less of the EPS nameplate | | | |
| | • | onthly, for a minimum of | | | |
| | _ | pter 3-5.4.2 of NFPA 99 | | | |
| | · · | record of inspection, | | | |
| | - | - | | | |
| | performance, exercising period, and repairs for the generator to be regularly | | | | |
| | maintained and available for inspection by | | | | |
| | | 2 - | | | |
| | - | ing jurisdiction. This | | | |
| | _ | e affect all residents in the | | | |
| | facility. | | | | |
| | Findings include | : | | | |
| | Based on a review o | of the Generator Testing Log | | | |
| | Book on 06/15/11 at | | | | |
| | _ | isor, the Generator Testing Log | | | |
| | | of the state of the for thirty minutes but did not | | | |
| | * | cent rated test was conducted | | | |
| | | t. The Generator Testing Log | | | |
| | | age and hertz during each test. | | | |
| | - | the maintenance supervisor at | | | |
| | the time of observati | 1011. | | | |
| | 3.1-19(b) | | | | |
| K0000 | | | | | |
| | | | | | |
| | A Life Safety Co | de Recertification and | K0000 | K00 The filing of this plan of | |
| | | | | correction does not constitu | ite an |

| STATEMEN | NT OF DEFICIENCIES | | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | |
|-----------|---|------------------------------|---------|--------|---|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | I DING | 02 | COMPL | ETED |
| | | 155730 | B. WIN | | | 06/15/2 | 011 |
| | | <u> </u> | P. 1111 | | ADDRESS, CITY, STATE, ZIP CODE | l | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | 1 | HITLATCH WAY | | |
| RIPLEY | CROSSING | | | 1 | IN47031 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ГЕ | COMPLETION |
| TAG | ! | LSC IDENTIFYING INFORMATION) | - | TAG | | | DATE |
| | State Licensure Survey was conducted by | | | | admission that the alleged deficiency did in fact exist. T | hie | |
| | the Indiana State Department of Health in | | | | plan of correction if filed as | 1113 | |
| | accordance with 42 CFR 483.70(a). | | | | evidence of the facilities des | ire to | |
| | Survey Date: 06 | 5/15/11 | | | comply with the regulation will continuing to provide quality of care to all residents. | | |
| | Facility Number | : 000420 | | | | | |
| | Provider Numbe | | | | | | |
| | AIM Number: 1 | | | | | | |
| | | | | | | | |
| | Surveyor Mark | Bugni, Life Safety Code | | | | | |
| | Specialist Specialist | zagm, zne suret, soue | | | | | |
| | Specialist | | | | | | |
| | At this Life Safe | ty Code survey, Ripley | | | | | |
| | | und not in compliance | | | | | |
| | 1 | nts for Participation in | | | | | |
| | 1 | aid, 42 CFR Subpart | | | | | |
| | | • | | | | | |
| | ` ' ' | Safety from Fire and the | | | | | |
| | 2000 edition of t | | | | | | |
| | | ciation (NFPA) 101, Life | | | | | |
| | ` | C), Chapter 18, New | | | | | |
| | | supancies, NFPA 101, Life | | | | | |
| | ` ` | C) and 410 IAC 16.2. | | | | | |
| | 1 | 5 Rehabilitation Wing | | | | | |
| | was surveyed wi | th Chapter 18, New | | | | | |
| | Health Care Occ | cupancies. | | | | | |
| | | | | | | | |
| | The 2007 Wing | 5 Rehabilitation Wing | | | | | |
| | addition to the o | ne story facility was | | | | | |
| | | e of Type V (111) | | | | | |
| | | fully sprinklered. The | | | | | |
| | | e alarm system with | | | | | |
| | I - | in the corridors, spaces | | | | | |
| | | dors, and all resident | | | | | |
| | open to the corri | dors, and all resident | | | | | |

| readily accessible at all times in accordance with section 7.1. 18.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 exit accesses in the Wing 5 Rehabilitation Wing supplied with a delayed egress lock was provided with a sign indicating, PUSH UNTIL ALARM SOUNDS DOOR K038 K038 K038 K038 K038 I. What corrective action will be accomplished: A sign was placed on the door, "push until alarm sounds, door can be opened in 30 seconds." other residents have the potential to be effected: All residents have the potential to be effected: 3 | 13 ID DT 13 I |
|--|---------------|
| NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Sleeping rooms. The facility has a capacity of 100 and had a census of 95 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following K0038 SS=E K0038 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 exit accesses in the Wing 5 Rehabilitation Wing supplied with a delayed egress lock was provided with a sign indicating, PUSH UNTIL ALARM SOUNDS DOOR STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN IN47031 STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN IN47031 STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN47031 STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN47031 (X4) ID PROVIDER PROVIDER PROVIDER PLANCE CORRECTION (CACHOOSEICTUR. ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DOAD PROFILE COMPL. TAG OF COMPL. | AND PLAN (|
| NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Sleeping rooms. The facility has a capacity of 100 and had a census of 95 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following K0038 SS=E Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 exit accesses in the Wing 5 Rehabilitation Wing supplied with a delayed egress lock was provided with a sign indicating, PUSH UNTIL ALARM SOUNDS DOOR STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN47031 CX PREFIX PREFIX TAG PROVIDER'S PLAN OF CORRECTION CROSS-REFERED CORRECTION COMPL PROVIDER'S PLAN OF CORRECTION CROSS-REFERED CORRECTION COMPL ACCOMPL PREFIX TAG PROVIDER'S PLAN OF CORRECTION CROSS-REFERED CORRECTION COMPL CROSS-REFERED CORRECTION COMPL ACCIONAL COMPL PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION CROSS-REFERED CORRECTION COMPL REGULATORY CORRECTION COMPL FROM TAGE PROVIDER'S PLAN OF CORRECTION CROSS-REFERED CORRECTION COMPL CROSS-REFERED CORRECTION COMPL CROSS-REFERED CORRECTION COMPL CROSS-REFERED CORRECTION COMPL CROSS-REFERED CORRECTION CORPORATE CROSS-REFERED CORRECTION COMPL PROVIDER CORRECTION CORPORATE CROSS-REFERED CORPORAT | |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Sleeping rooms. The facility has a capacity of 100 and had a census of 95 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 exit accesses in the Wing 5 Rehabilitation Wing supplied with a delayed egress lock was provided with a sign indicating, PUSH UNTIL ALARM SOUNDS DOOR PREFIX TAG REPOWDERS FLAND FORRECTION (EACH CORRECTION FLAND FORRECTION FLAND FORRECTION FLAND FL | |
| REGULATORY OR LSC IDENTIFYING INFORMATION) Sleeping rooms. The facility has a capacity of 100 and had a census of 95 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 exit accesses in the Wing 5 Rehabilitation Wing supplied with a delayed egress lock was provided with a sign indicating, PUSH UNTIL ALARM SOUNDS DOOR TAG CROSS-REFERENCED TO THE APPROPRIATE DAT DAT CROSS-REFERENCED TO THE APPROPRIATE DEAT DAT CROSS-REFERENCED TO THE APPROPRIATE DEAT DAT TAG POST TAG CROSS-REFERENCED TO THE APPROPRIATE DEAT DAT TAG TAG TAG TAG TAG TAG T | (X4) ID |
| sleeping rooms. The facility has a capacity of 100 and had a census of 95 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following K0038 SS=E Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 exit accesses in the Wing 5 Rehabilitation Wing supplied with a delayed egress lock was provided with a sign indicating, PUSH UNTIL ALARM SOUNDS DOOR SS=E R0038 K038 1. What corrective action will be accomplished: A sign was placed on the door, "push until alarm sounds, door can be opened in 30 seconds." 2. How other residents have the potential to be effected: All residents have the potential to be effected: 3 | PREFIX |
| capacity of 100 and had a census of 95 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 exit accesses in the Wing 5 Rehabilitation Wing supplied with a delayed egress lock was provided with a sign indicating, PUSH UNTIL ALARM SOUNDS DOOR K0038 K038 1. What corrective action will be accomplished: A sign was placed on the door, "push until alarm sounds, door can be opened in 30 seconds." 2. How other residents have the potential to be effected: All residents have the potential to be effected: All residents have the potential to be effected: 3 | TAG |
| CAN BE OPENED IN 15 SECONDS. LSC 7.2.1.6.1, requires approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided the following criteria are met: (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the | K0038 |
| actuation of any heat detector or activation of not more than two smoke | |

PRINTED: 07/12/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155730 | | A. BUII | LDING | NSTRUCTION 02 | (X3) DATE COMPI 06/15/2 | LETED | |
|---|---|--|--------|---------------------|--|-------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WIN | STREET A | DDRESS, CITY, STATE, ZIP CODE HITLATCH WAY IN47031 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | automatic fire de accordance with doors shall unloc controlling the lo mechanism. (c) shall release the upon application device required to be required to be required to be required to be comore than 3 secon release process signal in the vicit the door lock has application of for device, relocking means only. Exception: When authority having exceeding 30 second (d) On the door a device, there shad durable sign in less this high and not less width on a contrareads as follows: SOUNDS DOO 15 SECONDS. | An irreversible process lock within 15 seconds of a force to the release in 7.2.1.5.4 that shall not ceed 15 If nor be intinuously applied for onds. The initiation of the shall activate an audible inity of the door. Once is been released by the rice to the releasing grahall be by manual the approved by the jurisdiction, a delay no conds shall be permitted. Indigacent to the releasing libe a readily visible, exters not less than 1 inch than 1/8 inch in stroke that 1/8 inch in stroke | | | | | |

000420

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | |
|--|--|---|---|---------------|--|------------------------------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 02 | COMPL | ETED |
| | | 155730 | B. WING | | | 06/15/2 | 011 |
| | | | D. 1121 | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | 1200 W | HITLATCH WAY | | |
| | CROSSING | | | MILAN, | IN47031 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | * | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | re l | COMPLETION DATE |
| | p.m. with mainte Wing 5 Reanima | nance supervisor, the tion Wing end hall as equipped with a | | | | | |
| K0044 SS=E | delayed egress lowing 5 Rehability not provided with UNTIL ALARM BE OPENED IN was verified by the supervisor at the supe | ck. Furthermore, the ation Hall exit door was a sign indicating PUSH SOUNDS DOOR CAN 15 SECONDS. This he maintenance time of observation. used, are in accordance 2.5 vation and acility failed to are doors was ch. LSC 7.2.4.3.8 | K0 | 0044 | K44 1.What corrective action will be accomplished: The hinges on the doors were adjusted to allow positive latching. 2. How other resid have the potential to be effected. 3. What measures/changes have been put in place: Maintenance supervisor will monitor the daily x 1 week, then weekly monthly, then monthly. 4. In this corrective action will be monitored: | ents cted: ial to en doors x 1 How | 06/30/2011 |
| | each door oper deficient practi | ce could affect 18 reside on the Wing | | | Administrator/designee will monitor monthly. 5. What da these changes will be completed: June 30, 2011 | ate | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | | NSTRUCTION 02 | (X3) DATE S | ETED |
|--|--|---|---|---------------------|--|--------------------------------|----------------------------|
| | | 155730 | B. WING | | | 06/15/20 | 011 |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY | | | | |
| RIPLEY (| CROSSING | | | MILAN, | IN47031 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | F | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| K0052 SS=F | Based on observation whalf hour fire doc and failed to late 2:10 p.m. tour of latch during the frequency conducted at 3:30 by the maintenant of observations. 3.1-19(b) A fire alarm system installed, tested, a accordance with NCode and NFPA 7 approved mainten complying with approved m | e: ation on 06/15/11 with supervisor, the Wing 5 ing set of one and one ors was manually closed the on three attempts at the the facility, and failed to ire alarm system test in p.m. This was verified ce supervisor at the time or required for life safety is and maintained in in FPA 70 National Electrical in The system has an ance and testing program colicable requirements of | K00 | | K52 1.What corrective action be accomplished: The autor dialer box was replaced. 2 How other residents have the potential to be effected: All residents have the potential to be effected: All residents have the potential to effected. 3. What measures/changes have been put in place: The automatic will be checked 3 times per week times 1 month then monthly. 4. How this correct action will be monitored: Administrator or designee will monitor monthly. 5. What dat these changes will be | matic . e co be en dialer tive | 06/30/2011 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

J9VX21 Facility ID:

000420

If continuation sheet

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155730 | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 02 | (X3) DATE SURVEY COMPLETED 06/15/2011 | | |
|--|---|---|-----------------|--|------------|--|
| NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING | | STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN47031 | | | | |
| (X4) ID PREFIX | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | ID PREFIX | (X5) COMPLETION | | |
| TAG | AG REGULATORY OR LSC IDENTIFYING INFORMATION) Findings include: | | TAG | completed: June 30, 2011 | DATE | |
| | Based on an obsetesting with the r | ervation and fire alarm naintenance supervisor | | | | |
| | automatic dialer trouble from pho | 30 p.m., when the component was placed in ne line failure for twenty local trouble signal was | | | | |
| | not initiated at the located in the from | e digital dialer box nt entrance which was ccupied by facility staff, | | | | |
| | located at the Wi Based on an inte | | | | | |
| | maintenance supervisor on 06/15/11 at 3:50 p.m., the fire alarm system had an electrical problem a few months ago and | | | | | |
| | main panel then | trouble signal from the did not reconnect the | | | | |
| | the fire alarm systhe maintenance | Based on observation of stem electrical panel with supervisor on 06/15/11 at | | | | |
| | - | ectrical wiring feeding the us visibly disconnected. | | | | |
| 120144 | 3.1-19(b) | spected weekly and | | | | |
| K0144 SS=F | | oad for 30 minutes per | | | | |
| | Based on ol interview, the factors | oservation and acility failed to ensure 1 | K0144 | K144 1. What correction ac will be accomplished: The | 0//11/2011 | |

000420

| | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|------------------------------|---|---------------------------------------|----------------------------|----------|--|---------------------------------------|--|
| | | IDENTIFICATION NUMBER: | A. BUI | LDING | 02 | COMPLETED | |
| | 155730 | | B. WIN | NG | | 06/15/2011 | |
| NAME OF F | PROVIDER OR SUPPLIER | | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF TROVIDER OR GOTTELER | | | | 1 | HITLATCH WAY | | |
| RIPLEY (| CROSSING | | | MILAN, | IN47031 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | DATE | |
| | , | generators was | | | bank test will becompleted a least every year. This genera | l l | |
| | | a remote manual stop. | | | does not require a remote m | l l | |
| | | quires emergency | | | stopdue to its size, (see attached | l l | |
| | generators prov | • . | | | letter). 2. How other resident | | |
| | | ting systems shall be | | | havethe potential to be | | |
| | · · | d and maintained in | | | effected:All residents have the potentialto be effected. 3. W | • • • • • • • • • • • • • • • • • • • | |
| | | h NFPA 110, Standard | | | measures/changes have bee | • • • • • • • • • • • • • • • • • • • | |
| | | and Standby Power | | | put in place:The load bank to | | |
| | • | A 110, 1999 edition, | | | will be preformed annually | | |
| | 3-5.5.6 requires Level I installations | | | | duringscheduled semi annua | ıl | |
| | shall have a remote manual stop | | | | visits. 4. How this corrective actionwill be | | |
| | station of a type | e similar to a | | | monitored:Administrator or | | |
| | break-glass sta | tion located outside | | | designeewill monitor. 5. | | |
| | the room housi | ng the prime mover. | | | Completion date:July 11, 20 | 11 | |
| | NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Edition, at 8-2.2 | Edition, at 8-2.2(c) requires engines | | | | | |
| | of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect 18 residents who reside on the | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Wing 5 Reanim | ation Wing. | | | | | |
| | | | | | | | |
| | Findings includ | e: | | | | | |
| | | | | | | | |
| | Based on obse | rvation of the | | | | | |
| | emergency ger | nerator set and a tour | | | | | |
| | of the facility wi | th the maintenance | | | | | |
| | supervisor on 0 | 06/15/11 from 12:10 | | | | | |
| | p.m. to 4:05 p.r | m., there was no | | | | | |
| | emergency stop | p switch located | | | | | |
| | | ergency generator set | | | | | |
| | building, or in the | | | | | | |

| AND PLAN OF CORRECTION IDENT | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155730 | | LDING | NSTRUCTION 02 | (X3) DATE S COMPL 06/15/2 | ETED |
|---|--|--|---------|---------------------|---|--|----------------------------|
| NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING | | | B. WIIV | STREET A | ADDRESS, CITY, STATE, ZIP CODE HITLATCH WAY IN47031 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| | emergency gercylinder diesel the horsepower the side of the interview with a supervisor on the diesel general hundred horse and the facility failed testing for the partial for the emprotect 95 of 95 and 4.1.1 of NFF testing of the geremergency electraccordance with for Emergency a Systems, chapted NFPA 110 required and Level 2 secondary and Level 2 secondary and the standard percent from the standard percent for the geremergency electrating at least mandard percent for the geremergency electrating at least mandard percent from the standard percent from the geremergency electrating at least mandard percent from the geremergency electrating at least mandard percent from the geremergency experies for the geremergency experies for the geremergency experies for the geremergency electrating at least mandard percent from the geremergency experies for the geremergency electration and the standard percent for the geremergency electration and the standard percentage at the standard percen | nerator set was a six and lacked a listing of er on the nameplate on engine. Based on an the maintenance 06/15/11 at 3:45 p.m., erator is over one | | | | | |
| | | | | | | | |

PRINTED: 07/12/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 | | (X3) DATE SURVEY COMPLETED OC (15/2011 | | |
|--|---|---|---|-------------------------------|--|------------|--|
| 155730 | | B. WING | | 06/15/2011 | | | |
| NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN47031 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | | |
| PREFIX | (EACH DEFICIE | NCY MUST BE PERCEDED BY FULL | PREFIX | | | COMPLETION | |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | | DATE | |
| | the authority ha | ving jurisdiction. This | | | | | |
| | deficient practic | ee could affect 18 residents | | | | | |
| | who reside on V | Ving 5 Realization Wing. | | | | | |
| | Findings include | e: | | | | | |
| | Based on a review of the Generator Testing Log Book on 06/15/11 at 3:00 p.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for each of the past twelve months for thirty minutes but did not indicate a thirty percent rated test was conducted during each load test. The Generator Testing Log Book listed the voltage and hertz during each test. This was verified by the maintenance supervisor at the time of observation. | | | | | | |
| | 3.1-19(b) | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

J9VX21

Facility ID:

000420

If continuation sheet

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